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Marin Medicine

The magazine of the Marin Medical Society

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Medicine, Gender and Politics

Steve Osborn

I am a 58-year-old heterosexual male. History does not record when I first became aware of gender differences, but it was probably during my infancy, when I noticed that my mother looked and acted differently from my brother or father.

While growing up, my brother and I went through all the boyhood rituals of covering our eyes whenever actors and actresses kissed in the movies, followed in later years by ogling the Miss America contestants during the swimsuit competition. By the time I reached high school, I had basically one thing on my mind, and it wasn't homework. My fellow male scholars were likewise monomaniacal, and we wished that our female counterparts would be as well.

During high school I had a friend whom I'll call Alex who didn't seem nearly as obsessed with Playboy bunnies as the rest of the boys. While not an outcast, he mostly kept to himself, preferring studying to partying.

I fell out of touch with Alex during college and graduate school, but I tracked him down shortly afterward on a rare visit home. Over drinks at a bar, he disclosed that he had finally realized he was gay while writing his dissertation, and that the revelation had changed his life.

Nowadays Alex is a full professor at a major university and a world-famous expert in his field. He has lived with the same man for several decades, but they have never been able to get officially married. They have also spent many fruitless years trying to adopt a child. In his last Christmas letter, Alex confessed that they had finally given up hope.

In this issue of *Marin Medicine,* local and nationally renowned physicians explore the complex interactions of medicine, gender and politics—the same kinds of interactions that prolonged Alex's discovery of his sexual identity and continue to shape his struggle to be fully accepted into society.

We begin with an overview of lesbian, gay, bisexual and transgender (LGBT) medicine by Dr. Daniel Blumkin, a family physician in San Rafael. He notes that more than one-fourth of LGBT patients postpone care because of fear of discrimination, and that one way to make them feel welcome is to include a sexual-orientation question in the social history.

Dr. Ann Kao, a Larkspur cardiologist, offers a detailed review of cardiovascular disease in women. No longer considered a "man's disease," CVD in all its many forms is the No. 1 killer of women nationwide. Pregnancy is a particularly dangerous time for women at risk for CVD, but as Kao explains, much of that risk is preventable.

During the current presidential election campaign, politicians of all stripes have focused attention on gender-related medical issues, including the HPV vaccine and the Plan B morning-after pill. Rick Perry's failed attempt to mandate HPV vaccinations in Texas contributed to his early departure from the race, and HHS Secretary Kathleen Sebelius drew both scorn and praise for prohibiting over-the-counter sales of Plan B One-Step to females younger than 17.

For perspective on those issues, we've included articles on both HPV and Plan B. Former Marin County public health officer Dr. Jason Eberhart-Phillips clears away the confusion surrounding the HPV vaccine by furnishing a point-by-point analysis of its purpose, efficacy and use. Prevention of HPV-related cancers is a tantalizing possibility, but much work remains to be done.

Dr. Vicki Darrow, a pediatric and adolescent gynecologist for Kaiser Permanente, minces no words in her condemnation of the Sebelius decision on Plan B, calling it "an unwanted intrusion of politics into public health." She argues that unrestricted access to the medication could significantly decrease the rate of unintended pregnancies in adolescents.

We conclude the feature articles with an exclusive interview with former Surgeon General Dr. Richard Carmona, who completed medical school and residency at UC San Francisco. He gives an insider's view of the role of politics in public health. Recalling the pressures he faced during his tenure with the Bush Administration, he offers potential solutions to the ongoing conflict between politics and science.

The diversity of the feature articles in this issue is matched by the departments, which range from a timely reminder by Dr. Jim Dietz about the proper use of emergency departments, to a set of poems about the ED and other medical settings by Dr. Catharine Clark-Sayles. In between are helpful comparisons of physician retirement options by Jonathan Leidy, an update on Kentfield Rehabilitation & Specialty Hospital by Simone Adams, and a review of local author Dr. Martin Rossman's new book by the chair of our editorial board, Dr. Irina deFischer. ◇

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Asking the Sexual-Orientation Question

Daniel Blumkin, MD

When dealing with lesbian, gay, bisexual and transgender (LGBT) patients, the easiest route for physicians is to avoid that initial question about sexual orientation and proceed with the patient's care while ignoring this important piece of information. For many doctors, asking such a personal question feels invasive.

In my experience, the sexual-orientation question is best treated as part of a complete social history. If your pattern is to ask about smoking, alcohol and recreational drug consumption, simply continue to ask if the patient is sexually active, and if he or she has sex with men, women, or both. When these questions become part of your script, they will flow like all your history questions and will not feel any more awkward than any other question.

Why ask the sexual-orientation question? There are many reasons. LGBT patients are at increased risk for developing certain cancers and of having sexually transmitted diseases. The CDC recommends that LGBT patients be screened for STDs every year; some may even request more frequent testing. When offering testing, it is important to discuss sexual behavior and counsel about risky sexual practices. In addition, LGBT patients should be immunized for hepatitis A and B.

Dr. Blumkin is a family physician at Kaiser San Rafael.

LGBT patients are also more likely than straight patients to drink alcohol, smoke tobacco, use drugs and attempt suicide. Of even more importance, more than 25% of LGBT patients in a recent survey reported postponing medical care for sickness or injury due to concerns about discrimination.[1] Postponing care is possibly the highest health risk for LGBT patients. As compassionate care providers, we need to do what we can to make them feel comfortable in our offices.

Probably no more than 3% of my patients are LGBT. Many of them are over 50 years old, and there was no documentation in their charts that they were LGBT when I first met them. Surprisingly, the sexual-orientation question in my routine social history put them at ease, probably because that was no longer a hidden piece of information. They became more conversational, more willing to share a story that didn't have to be censored or use gender-neutral pronouns.

Knowing an LGBT patient's current family status is helpful as well. They may be in a family setting with children at home, information that could be important when evaluating an infectious illness, rash or other diagnostic issue. Lesbians who have never been pregnant are at higher risk for breast cancer and should be screened regularly. Male-to-female transgendered patients will have an intact prostate, and they should be offered the same information as male patients about screening for prostate cancer.

I am listed in the Gay Lesbian Medical Association directory of LGBT-friendly physicians and have received emails from patients as far away as the South Bay asking for help because they feel uncomfortable with their current physician. One such patient had a question about pain with unprotected anal sex. I responded by attempting to use a vocabulary that reflected the words he used, to avoid putting him off. I offered to communicate with him via email when appropriate, since it is unlikely he is going to travel to San Rafael for care.

As a family physician, I often try to let patients know that the "family" in family physician is defined by them, not by me or by society. I attempt to be as inclusive as possible. Last year in the course of a social history, a new patient told me he was gay. I saw that he was wearing a wedding band, and I asked if he was married. He beamed and answered yes. Two questions later I inquired who lived at home with him, and he told me that he lived with his partner. I answered, "Don't you mean your husband?" I asked that question for a few reasons, but one was to state clearly that I recognized his relationship and valued it. I trust he will never hesitate to delay care or withhold information from me out of fear of being judged or discriminated against.

The care of transgendered patients requires even more delicacy in finding a balance between obtaining information and protecting privacy. When I was still a resident in New York City, I attended a grand rounds that featured transgendered speakers, and I have never forgotten their indignation when they reported having a genital examination for a upper respiratory infection when they presented in the emergency room. They said this was not uncommon. Apparently many physicians are curious to see whether transgendered patients are pre- or postoperative. The question might be pertinent at a complete physical, but only the question. The exam is only pertinent if there is an issue in that area.

With computerized health records, many transgendered patients do not have correct gender assignments in their chart. Most records are also used for billing, and the gender must be consistent with the gender the insurer has on file. Making the first entry on the problem list "Transgender M to F, pre-operative" prevents a lot of confusion and discussion.

Transgendered patients are more likely than the general population to have experienced violence at home or from discrimination. By recognizing this risk, looking for signs and asking specific questions, we physicians can help provide these patients with the medical and social interventions they need.

I once heard a moving personal account of the difficulties LGBT people face in our culture. Being LGBT was compared to being deaf. A deaf child may be born to hearing parents. In most instances, those parents will immediately seek support and help for their child. Their child will be identified by educators and given as many opportunities as possible, including various support networks.

Not so for the LGBT child. That child will usually be born into a family of heterosexual adults. The child will recognize, some at a very early age, that there is a difference that he or she is feeling inside that is difficult to express. As the child becomes older, he or she realizes that this difference is not welcomed by many people in our society. The support available to other children and teens is often not there for the young LGBT person.

Providing a safe, welcoming environment for the LGBT community in our offices is a small step we can take to offer some support. Whether the person is a brave, self-assured 18-year-old or a troubled 55-year-old finally coming to terms with their true identity, we can offer them help by being open and nonjudgmental. ◇

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Reference

1. Grant JM, et al, "National Transgender Discrimination Survey Report on Health and Health Care," National Center for Transgender Equality, transequality.org (2010).

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Heart Disease in Women: Where are we now?

Ann Kao, MD

During the 1960s, the American Heart Association sponsored a conference titled "How Can I Help My Husband Cope with Heart Disease?" Half a century later, substantial progress has been achieved in debunking the myth that cardiovascular disease is a "man's disease." Cardiovascular disease (CVD) is the leading cause of mortality in both women and men, responsible for one-third of all deaths.

Coronary Heart Disease

Dr. Bernadine Healy introduced the concept of the "Yentl syndrome" in a 1991 article,[1] suggesting gender bias in the recognition and management of coronary heart disease (CHD). Since then, sex-exclusive scientific and clinical research is no longer the norm. Multiple studies in the past two decades with conflicting information about rates of CHD mortality among women compared to men have fueled the debate of whether gender differentially modulates CHD mortality and why. It is now generally recognized that the sex-based differences in CHD can be largely explained by different clinical characteristics.[2-5] Women, as a group, are older when they present with disease, and have more comorbidities, including hypertension, hyperlipidemia, diabetes and heart failure. In addition, there is gender difference in angiographic severity, with women having fewer obstructive lesions and less frequent two- and three-vessel coronary artery disease.[4]

Dr. Kao is a board certified cardiologist at Cardiovascular Associates of Marin in Larkspur.

A large cohort analysis of data from the National Registry of Myocardial Infarction (NRMI), published in 1999, demonstrated a higher risk of early death after myocardial infarction for younger women compared with younger men, but no gender-related mortality difference in the older population. The younger the age of the patients, the higher the risk of hospital mortality among women compared to men. This interaction between sex and age raises the possibility that coronary atherosclerosis in younger women may have a unique pathophysiology which manifests in more aggressive disease.[5]

An analysis reported in 2009 of a cohort of 136,247 patients (28% women) pooled from 11 international trials, suggested that while sex-based differences in 30-day mortality exist in acute coronary syndrome (ACS) and vary depending on the type of syndrome, the differences are markedly attenuated after adjustment of clinical and angiographic differences.[6] In this analysis, no interaction between sex and age was detected, but a significant correlation between sex and the type of ACS was observed. The higher 30-day mortality rate among women compared to men appears to be limited primarily to ST-segment elevation myocardial infarction (STEMI), while a lower 30-day mortality risk was seen in non-STEMI and unstable angina. It is possible that the intrinsic sex-based differences in the type of culprit lesion, the degree of angiogenesis and collateralization, and the extent of angiographic disease burden can partly explain these findings.

A more recent NRMI evaluation of outcomes from 1994 to 2006, published in 2009,[7] showed that women, particularly younger women, compared to men, experienced a larger decrease in hospital mortality after an acute MI. The absolute reduction for the cohorts <55 years old was three times larger in women than men (2.7% vs 0.9%). Over 90% of this decreased mortality in younger women compared with men was attributed to a greater improvement of risk factors. Thus, the difference in MI mortality for younger women as compared to younger men has markedly narrowed in the decade between NRMI reports.

Heart Failure

The focus of public education on heart disease in the past two decades has been on coronary heart disease, which is the largest contributor to CVD and accounts for nearly 50% of the female CVD mortality. Heart failure (HF), despite its contribution to 35% of that death toll, has received much less public attention. The prevalence of

HF increases with age in both genders. Of the 5.3 million Americans afflicted with HF, nearly 50% are women, with more women than men having HF after the age of 79. Studies have shown that women with HF have lower quality of life, more functional impairment, more hospital stays and higher incidence of depression. Nonetheless, HF survival appears better for women.

The sex difference in HF survival is not entirely explained by LV systolic function or by etiology. Several experimental studies point to sex-related fundamental differences in the nature and degree of myocardial remodeling, which may contribute to the female survival advantage. About one-half of patients with HF have preserved ejection fraction (HFpEF), which is often described as "diastolic dysfunction." The pathophysiology of HFpEF is poorly understood, and there is ongoing debate about whether it is part of the HF spectrum or a distinct pathophysiologic entity fundamentally different from the much better understood HF with reduced ejection fraction (HFrEF).

The HFpEF patient population is older, more likely to be hypertensive and more often female.[8] The "preserved" systolic function does not denote good prognosis. In prospective studies of HFpEF, the mortality is comparable to HFrEF. Therapies such as ACE inhibitors and beta blockers that have demonstrated unequivocal benefit in HFrEF have not shown consistent efficacy in HFpEF. Diuretics are effective in relieving HF symptoms in both HFpEF and HFrEF, but there is scant evidence showing their effect on clinical outcome. Diagnosis of HFpEF is frequently challenging, relying on careful clinical evaluation, echo-Doppler cardiography and invasive hemodynamic monitoring. Many outpatients with chronic unexplained dyspnea attributed to deconditioning or overweight may have HFpEF. A higher level of awareness and a better understanding of this disease entity are needed since its prevalence is on the rise.

CVD in Pregnancy

Normal pregnancy is associated with a 30-50% increase in blood volume. About 40-100% plasma volume expansion is reached at 32-34 weeks, along with 20-30% increase in the red cell mass, thus creating a "physiologic anemia" that reduces the impact of blood loss during delivery, typically 300-500 cc for a vaginal delivery and 750-1000 cc for a C-section. An augmented cardiac output parallels the increase in blood volume, accomplished by a 35% increase in the stroke volume and a small rise in the basal heart rate.

Cardiovascular diseases are the most common cause of maternal death during pregnancy in the Western industrialized world, and occur in approximately 0.4% to 4% of all pregnancies.[9] While not routinely anticipated, incipient cardiac diseases such as peripartum cardiomyopathy (PPCM), spontaneous coronary dissection and aortic dissection are among the "must not miss" diagnoses in late pregnancy. Shortness of breath at that stage may either reflect increased minute ventilation due to mechanical interference with diaphragmatic expansion by the gravid uterus, or the possibility of a serious and pathologic cardiopulmonary process.

PPCM presents in the last month of pregnancy or within 5 months postpartum. It is estimated to occur in 1 of 4,000 pregnancies in the U.S.[10] Risk factors include high parity, advanced maternal age, usage of tocolytics, African descent and twin pregnancy. The etiology is unknown, but experimental data have identified inflammation, autoimmune processes, apoptosis and impaired cardiac microvasculature as some pathophysiologic features. Recent data have shown that pregnancy-related imbalance of oxidative stress is linked to proteolytic cleavage of the nursing hormone prolactin, and produces a potent anti-angiogenic, pro-apoptotic and pro-inflammatory factor.[11]

Bromocriptine, a dopamine D2 receptor agonist that inhibits prolactin secretion, has been shown to improve recovery from PPCM in pilot studies.[12]

There is enthusiasm about this new therapy, but large clinical studies are needed to validate the result. Currently, about one-half of PPCM patients recover normal systolic function within 6 months. On the other hand, 20% of PPCM patients deteriorate and either die or require heart transplantation.

Spontaneous coronary artery dissection is rare. In comparison with the usual myocardial infarction population, it occurs in relatively young people, with a striking predilection for women. Eighty percent of all spontaneous coronary artery dissections occur in women,[13] and one-third of these occur during pregnancy or the postpartum period. A variation in hormonal levels is thought to play an etiologic role.

During pregnancy, altered endocrine status may cause changes in the arterial wall, including fragmentation of reticulin fibers, loosening of ground substance, and smooth-muscle hypertrophy. These changes may participate in the pathogenesis of spontaneous coronary dissection.[14] Seventy-eight percent of women with peripartum coronary dissection have no risk factors for coronary artery disease, and 84% of the lesions involve the left anterior descending artery.[15] Early intervention with either percutaneous coronary intervention or bypass surgery may be associated with better outcomes than conservative management,[16] but the studies to date are not conclusive, and no guidelines have been established.

Acute aortic dissection may occur in pregnancy in the setting of severe hypertension due to preeclampsia, coarctation of the aorta, bicuspid aortic valve, or connective issue diseases such as Marfan's syndrome.[17] The main predisposing factor is degeneration of the collagen and elastin in the intima and media. On the basis that 50% of all aortic dissections in women under age 40 occur during pregnancy or the puerperium, it is often stated that pregnancy is a risk factor for aortic dissection. The most common site of pregnancy-associated aortic dissection is the proximal aorta, and aortic rupture usually occurs during the third trimester or the first stage of labor.

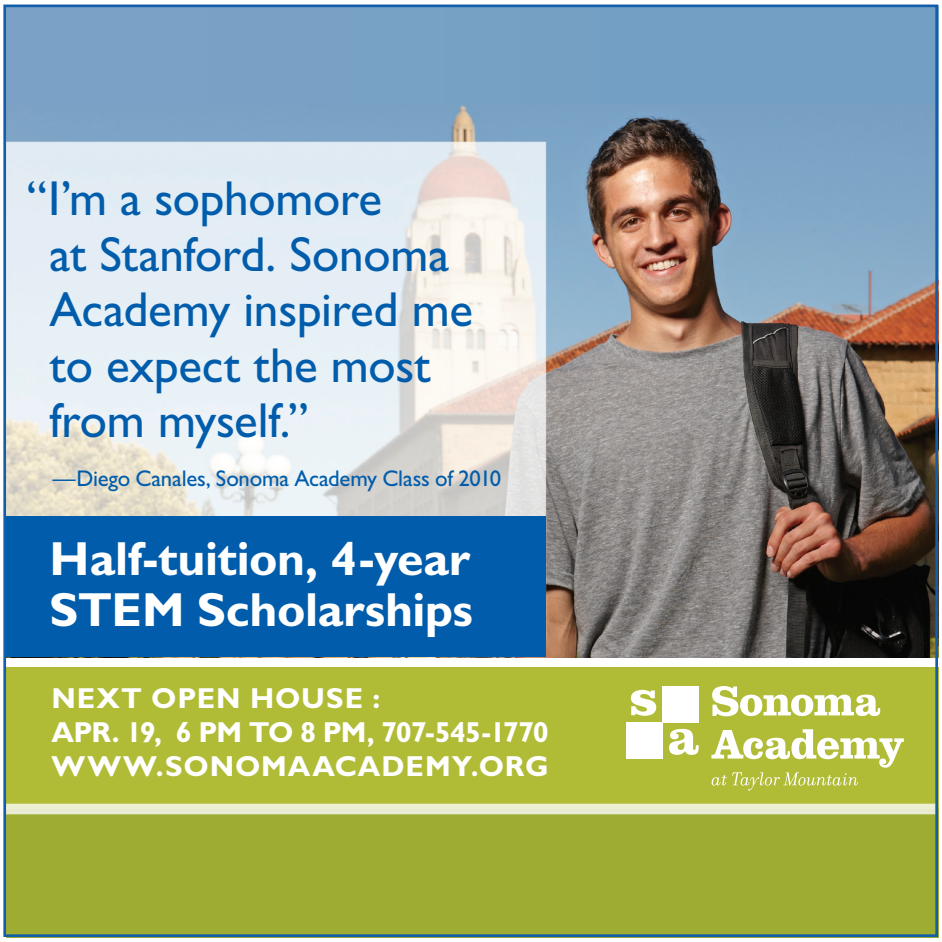
In general, pregnant women tolerate valvular insufficiency better than stenosis because the reduced systemic vascular resistance improves forward flow and limits the effects of regurgitation. The dramatic physiologic demands make pregnancy highly risky for women with certain conditions, including Marfan syndrome with dilated aortic root (>4cm), pulmonary hypertension (pulmonary vascular resistance >6 Wood units), moderate to severe left ventricular outflow obstruction (>30 mmHg), and left ventricular ejection fraction <30%.

Primary pulmonary hypertension is a rare disease that particularly affects young women of child-bearing age. It is characterized by medial thickening and intimal fibrosis. The mortality of pregnant mothers with primary pulmonary hypertension has been reported to be 30%. Secondary pulmonary hypertension has a perinatal mortality as high as 60%.[18]

Stroke

The third leading cause of death in women and men in the U.S. is stroke. When compared to men, women have a relatively greater proportion of stroke than of myocardial infarction. Each year, approximately 55,000 more women than men suffer a stroke. Data from the Women's Health Study showed the ratio of stroke to MI to be 1.4 to 1 among women in their placebo group, whereas among men of similar age in the Physician's Health Study, the ratio was 0.4 to 1.[19,20] Even after adjustment for older age of stroke onset, women have poorer outcomes, greater disability, a higher likelihood for admission to nursing facilities, and greater mental impairment than men.

Hypertension is the most important modifiable risk factor for stroke. Although women and men have nearly equal percentage of hypertension (one in three adults), the prevalence is higher in women older than 65, with the highest rate found among black women, at 44% and increasing.[21]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Any discussion of stroke and CVD prevention inevitably leads to the role of aspirin. In secondary prevention, low-dose aspirin (75-150 mg daily) clearly reduces the risk of cardiovascular events, myocardial infarction and ischemic stroke in both men and women.[22] However, aspirin's utility in primary prevention shows a sex-based difference. Aggregate data from six trials with a total of 95,456 individuals showed that aspirin therapy in women was associated with a 17% reduction in stroke but no significant effect on myocardial infarction. In contrast, there was a 32% reduction in the risk of myocardial infarction in men and no significant impact on the risk of stroke.[23] Analysis of data from the Women's Health Study showed that in women 65 and older, aspirin use was associated with a significant risk reduction in ischemic stroke and a small risk reduction in MI. Among women younger than 65, there was no benefit in MI and a small benefit in reduction of stroke risk.[20]

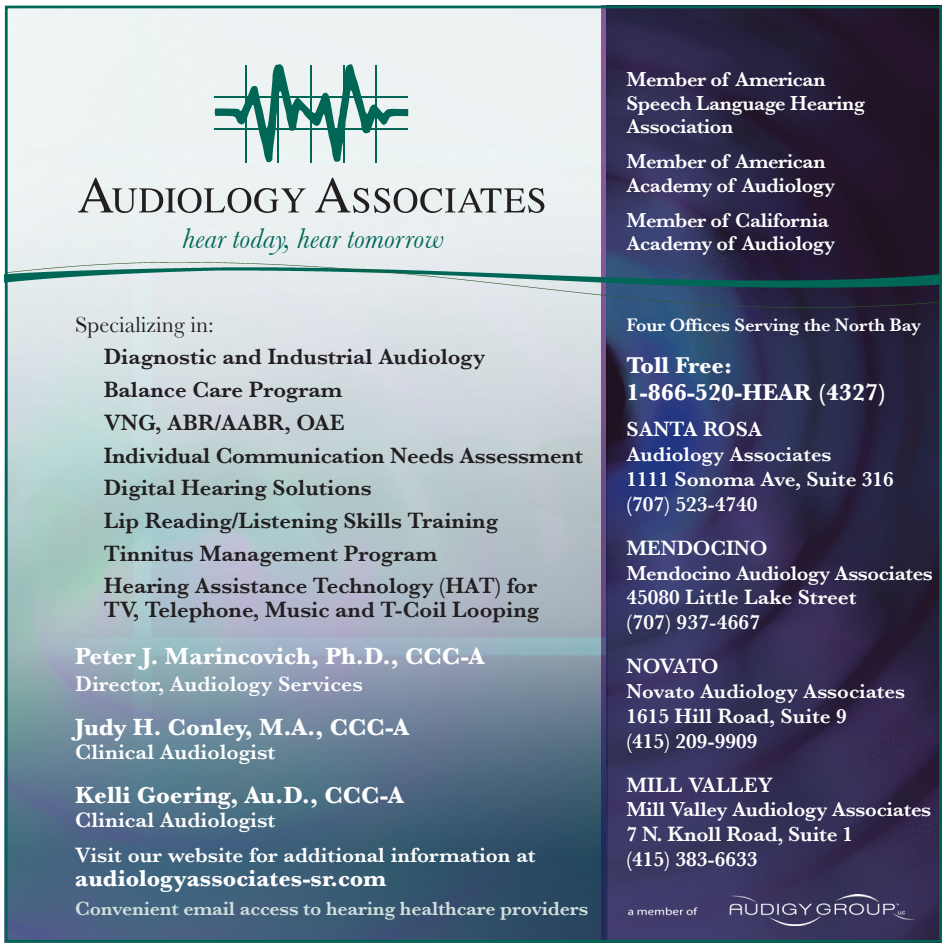
The American Heart Association (AHA) suggests that aspirin therapy can be useful in primary prevention in women 65 and older if blood pressure is controlled and benefit for the prevention of ischemic stroke and myocardial infarction is deemed to outweigh risks of gastrointestinal bleeding and hemorrhagic stroke. The AHA also suggests that aspirin use may be reasonable in women younger than 65 for prevention of ischemic stroke, but recommends against its routine use in healthy women younger than 65 for the purpose of MI prevention.[24]

For the same primary prevention population, the U.S. Preventive Services Task Force (USPSTF) recommends the use of aspirin for women age 55 to 79 when the potential benefit of a reduction in ischemic stroke outweighs the potential harm of an increased risk of gastrointestinal hemorrhage, and the task force recommends against the use of aspirin for stroke prevention in women younger than 55.[25] For men in the age group 45 to 79, the USPSTF recommends aspirin use when the potential benefit of reducing the risk of myocardial infarction, not ischemic stroke, outweighs the potential harm from an increase in gastrointestinal bleed.

The age group 80 years and older has not been well represented in the many studies used to formulate the guideline recommendations. While the incidence of MI and stroke is high in persons 80 years and older, the relationship between increased age and bleeding is also well established. Current evidence is insufficient to evaluate the balance of benefits and harms of aspirin for CVD prevention in this older age group. The easy availability of aspirin, with its direct marketing to patients without the context of age and gender differences in risks and benefits, complicates the issue of aspirin chemoprevention and underscores the importance of individual counseling.

Atrial fibrillation requires separate emphasis as a stroke risk. This arrhythmia is independently associated with a four- to five-fold increase in the risk of ischemic stroke, and is responsible for 15-20% of all ischemic strokes.[26,27] Women with non-valvular atrial fibrillation have nearly double the chance of stroke compared to men with the same risk profile. Use of warfarin anticoagulation for thromboembolic prophylaxis substantially lowers the risk of stroke in both men and women, by 60% and 84% respectively. No sex-related differences in the risk of bleeding were found in a recent systematic review of bleeding complications, but use of warfarin has been reported to be less common in women than in men.[28] Appropriately, the expert panel for AHA's 2011 updated guideline for the Prevention of Cardiovascular Disease in Women included a recommendation for the pharmacologic prevention of stroke among women with atrial fibrillation.

Other stroke risk factors unique to women include pregnancy and the use of exogenous hormones for menopausal symptoms. The major physiologic changes that occur during pregnancy may "unmask" a predisposition to vascular pathology. Although cerebrovascular complications occur in a



very small proportion of women with preeclampsia (<1%), they carry devastating morbidity and mortality. Primary care physicians and ob-gyns should be aware that a history of preeclampsia is associated with a future risk for hypertension, stroke and heart disease. In a way, pregnancy serves as a natural stress test and provides a unique opportunity to identify women at risk for cardiovascular disease.

Hormone Replacement Therapy

Since its approval by the FDA in 1942, estrogen has been used to alleviate the vasomotor symptoms of menopause and has been advocated for a variety of perceived health benefits, including CHD risk reduction. By the 1990s, the most compelling argument for hormone replacement therapy (HRT) in heart disease prevention came from observational studies. In 1998, the Heart and Estrogen/Progesterone Replacement Study—the first large, randomized, blinded, placebo-controlled secondary prevention trial—showed no cumulative difference of CHD events between HRT and placebo, with an increased risk of MI in the first year after initiation of hormone therapy, and an increased risk of venous thromboembolism.[29] This study was followed in 2002 by the release of data on primary prevention from the Women's Health Initiative (WHI) showing that HRT did not prevent incident CHD and actually increased the risk of stroke and invasive breast cancer in apparently healthy women.[30]

These results led the FDA and the AHA to recommend against the use of HRT for either primary or secondary prevention of CVD in women. However, HRT remains the most effective treatment available for the disruptive symptoms of menopause. Controversy and interest in this powerful drug continue to spark energetic debate and research. The concept of "time trend"—which postulates an immediate prothrombotic and pro-arrhythmic effect of estrogen that is later outweighed by its beneficial effect on the vascular endothelial function—was forwarded to explain the finding of increased CHD events in the first year and decreased risk in subsequent years.

Another concept relates to the "timing" of HRT. The WHI enrolled women with a mean age of 63, who were on average 12 years post menopause. The "timing" hypothesis argues that significant vascular disease may have already been present in the study population at the initiation of HRT, so estrogen may not reverse established pathological atherosclerosis. A subset analysis of WHI women aged 50 to 59 post-hysterectomy who received only estrogen suggested lower heart disease risk. This finding lends support to the concept that with proper "timing," estrogen given in low doses early in the menopausal transition may be cardioprotective. The ongoing Kronos Early Estrogen Prevention Study is investigating estrogen and intermittent progestin on atherosclerosis in a younger population, and its pending result may shed some light on this complex area.

CVD Prevention

A crucial aspect of contemporary cardiovascular medicine is the appreciation that much of CVD is preventable, which increases the need for timely identification of younger women at risk. The most established tool of risk assessment has been the Framingham Risk Score, which consists of criteria used to develop the National Cholesterol Education Program guidelines for lipid therapy.[31]

The Framingham score focuses on the short-term 10-year risk, and only on MI and CHD deaths. Since women develop CVD 5-10 years later than men, and their risks for stroke and heart failure through middle and older age typically exceed their risk for CHD, the Framingham score traditionally underestimates the risk in younger women and hence their need for preventive interventions.[32] For example, women with poor exercise capacity or unhealthy lifestyles have a broad range of risk for CVD, but may have a relatively low Framingham score.

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The lifetime risk for CVD is high in almost all women and approaches 1 in 2 on average. Focus on a woman's lifetime risk underscores the importance of a healthy lifestyle and may also better communicate future risk. For example, a 25-year-old woman with hypertension, diabetes and adverse lipid profile might be more likely to adopt the necessary lifestyle modification upon hearing that her 30-year risk of CVD is higher than 1 in 4, than when she is told that her 10-year risk is 1 in 40.[33]

Women also need to be better educated about the ineffectiveness of certain practices, such as supplementation with antioxidants and folic acid,[34] and focus their energy on effective preventive measures, including healthy diet, weight management, regular physical activity and abstinence from smoking. While certain impediments in clinical practice (such as time pressure, complex comorbidities and socioeconomic issues) undermine delivery of successful preventive care, the reality remains that physician-led, multidimensional interactions provide the most impact on the patients' adoption of healthy behavior.

Over time, the barriers to implementation must be tackled systematically to give physicians the ability to effect behavioral changes and monitor adherence to therapy. By doing so, we will achieve the goal of greater longevity and better quality of life for all our patients—both women and men. ◇

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HPV Vaccine Update

Jason Eberhart-Phillips, MD, MPH

Vaccines have recently become targets of controversy, but none have stimulated more debate than the two vaccines now approved to prevent cervical and other anogenital cancers caused by specific types of the human papillomavirus (HPV). Former presidential candidate Michele Bachmann, a U.S. representative from Minnesota, drew attention last fall when she called the HPV vaccine "a dangerous drug" and repeated on national media a woman's claim that her child had become mentally retarded as a result of getting the vaccine. Most controversial have been efforts to make HPV vaccination mandatory, as was attempted in Texas under a 2007 executive order by Gov. Rick Perry. Before dropping out of the race for president in January, Perry faced repeated attacks from his presidential rivals over his failed mandate. Rick Santorum, another presidential hopeful and a former U.S. senator from Pennsylvania, said, "There is no government purpose served for having little girls inoculated at the force and compulsion of the government."

Dr. Eberhart-Phillips is the former public health officer for Marin County.

Just as the political rancor about the HPV vaccine peaked last October, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention expanded its recommendations for routine use of quadrivalent HPV vaccine, also known as Gardasil, to include males aged 11 or 12 years. The ACIP also recommended catch-up vaccination for unimmunized males aged 13 to 21 years and for men who have sex with other men up to age 26 years. This recommendation brought the guidance for boys and men into greater alignment with that first given for girls and women in 2007.

The remainder of this article addresses some of the basic questions local physicians may have about HPV vaccination.

Q: How common is HPV infection in the United States? In Marin County? What are the consequences of such infection?

HPV is the most common sexually transmitted infection in the United States. About 20 million Americans are currently infected with genital HPV, and the CDC estimates that there are 6.2 million new infections each year, with 75% of these occurring in people 15 to 24 years of age.[1] Infection with HPV often comes soon after the initiation of sexual activity. In one prospective study of female college students, 39% of women who were virgins at the start of the study had become infected with HPV within 24 months of first intercourse.[2]

The vast majority of genital HPV infections are unnoticed and resolve spontaneously, but some infections can become persistent, and those due to more than a dozen so-called "high-risk" types may lead over time to precancerous changes in cells of the cervix, vulva, vagina, anus or penis. The American Cancer Society estimates that about 12,710 new cases of cervical cancer were diagnosed in the United States in 2011, and that about 4,290 American women die from the disease each year.[3] Nearly all these cases are thought to be due to HPV infection, with types 16 and 18—the oncogenic types covered by both vaccines—accounting for 70% of the total. High-risk HPV types are also responsible for about 90% of anal cancers, about 40% of vulvar, vaginal and penile cancers, and about 12% of oral and pharyngeal cancers. In addition, more than 90% of genital warts, which affect about 1% of the sexually active population, are associated with HPV types 6 and 11, both of which are covered by the quadrivalent vaccine (HPV4).

There is no population-based system to measure HPV infection in Marin County, but there were 27 cases of invasive cervical cancer diagnosed in the county from 2007 to 2009. This represents an annual age-adjusted rate of

5.97/100,000, compared to 8.18/100,000 for California as a whole. The county's annual death rate from cervical cancer has averaged 1.52/100,000 since 2000, compared to 2.43/100,000 statewide.[4]

Q: How effective is HPV vaccine in preventing infection in women? In men?

Both HPV4 and the bivalent vaccine (HPV2, also called Cervarix) are inactivated subunit vaccines produced by recombinant DNA technology, and both are highly immunogenic in uninfected recipients. Within a month of completing the three-dose series, more than 99% of recipients show evidence of antibodies to each of the vaccine virus types with which they have not already been infected. In clinical trials, both vaccines were found to be highly efficacious in preventing cervical disease associated with HPV-16 and 18. The efficacy of HPV4 has been measured at 98% against vaccine type-specific cervical intraepithelial neoplasia grades 2 or 3 and adenocarcinoma in-situ, after a mean follow-up time of 42 months.[5] The efficacy of HPV2 was 93% against the same endpoints after a mean follow-up of 35 months.[6] In males the efficacy of HPV4 against genital warts is thought to be nearly 90%.[7] Among men who have sex with men, HPV4's efficacy against vaccine type-specific anal intraepithelial neoplasia has recently been estimated at 78%.[7] In either sex, the duration of protection against HPV after immunization is unknown. There is no known serologic correlative of immunity, but a subset of trial participants has shown no waning of protection after more than five years.

As effective as the vaccine can be in clinical trials, there is no evidence of efficacy against disease caused by a type of HPV with which a patient is already infected. The vaccines are prophylactic; they have no therapeutic effect on existing infections or disease. Given how quickly infection with HPV can occur following sexual debut, the vaccine is maximally effective if given before an adolescent becomes sexually active. For this reason the recommended age for completing the three-dose course is 11 or 12 years. The vaccines can be given later (up to age 26 years for HPV4 and 25 years for HPV2), but population benefits decrease with increasing age of administration.

Q: What are the main arguments for and against HPV vaccination?

The main arguments in favor of HPV vaccination center on effectiveness and safety. While it is too early to see a significant reduction in the burden of invasive HPV-related cancers, the vaccine's high efficacy against intermediate endpoints demonstrated in clinical trials suggests that over time it will become an important tool for preventing cervical cancer and other anogenital cancers. This promising outcome is being achieved with a strong record of safety. More than 35 million doses of HPV vaccine have been given so far with no increased risk of serious adverse reactions, based on monitoring by the CDC.[8] Local reactions such as pain, redness or swelling at the site of injection do occur, but they resolve quickly.

On the other side are a number of arguments questioning whether enough is known about the vaccine's effectiveness to justify the cost and effort of a universal vaccination program. While the vaccine is highly effective in reducing precancerous cervical lesions caused by types 16 and 18, there is still no conclusive evidence that it can prevent cervical cancer or deaths. There is also no assurance that the duration of immunity will be long enough after age 11 or 12 years to protect recipients throughout their sexually active lives. Since 30% of cervical cancers are associated with types not covered by the vaccine, use of the vaccine does not eliminate the need for regular cervical cancer screening with the Pap test. Some critics argue that with effective screening there is no need for immunization, and that vaccination may even be harmful if some women falsely believe that they need not bother with continued screening. Critics also argue that over time the effectiveness of the vaccine may be lost if the selective pressure it exerts on the virus leads to the emergence of other oncogenic strains not covered by the vaccine.[9] There is no evidence that HPV immunization is associated with increased sexual risk-taking among adolescents, but this too is a concern that many parents share.

With all the doubts about the vaccine—and its cost of about $130 per dose—it is no surprise that only about one-third of US teenage girls have been fully vaccinated against HPV, and that fewer than half have even begun the series.[10]

Q: Should HPV vaccination be mandated for girls and women? For boys and men?

The lack of acceptance of the HPV vaccine by large segments of the general population should give us pause in using the law to reduce HPV-related cancers. Public discourse on HPV vaccine mandates inevitably raises divisive questions about adolescent sex, parental responsibility, the role of government in family decision-making, and the reported influence of the pharmaceutical industry on the political process. It would be far better if parents and adolescents themselves understood the risks that HPV infections pose and appreciated the benefits of receiving the vaccine well before exposure occurs. If that happens, we might see a higher uptake of vaccine, making mandates less important.

Q: In the absence of mandates, what can physicians and other agencies do to stop HPV infection?

Physicians can use their enormous influence to educate parents and their children alike on the risks of not being immunized, and the need to consider HPV vaccine at the 11- or 12-year-old visit. For a parent who believes the vaccine is unnecessary because they are certain their child will delay sexual activity until marriage, it may be helpful to explain that without the vaccine the child will one day be at risk of exposure if the future spouse has ever had sex before. Other parents may be persuaded

if they are reminded that in America today more than one-quarter of boys and girls have had sexual intercourse by age 16.[11] It might be helpful to add that HPV can be transmitted through nonpenetrative sexual activity, which is common among adolescents, and that using condoms does not eliminate risk.

Q: How does the HPV vaccine fit into the larger debate about vaccinations? Is it as important as other vaccinations? Should certain vaccinations have priority?

I would hesitate to say one vaccine is more important than another. Is it better to die from measles, meningitis or cervical cancer? They are all equally bad outcomes, and the best evidence we have is that these diseases, like many others, are preventable when people follow the guidelines and accept the vaccines being offered.

Q: What is the role of the drug companies in this debate? How do they stand to profit from the HPV vaccine? What influence do they have on public policy?

The two HPV vaccines were developed and manufactured by two of the world's largest pharmaceutical companies. These companies certainly expect to recover their costs and earn their shareholders a profit, as they do with any other product. Having said that, revelations about lobbying by one of those companies for compulsory vaccination laws may have tarnished the public's confidence in the public health value of the HPV vaccine. Perceptions of unseemly political interference by the pharmaceutical industry are never helpful in encouraging vaccine uptake.

Q: What is the status of vaccination efforts in California?

The recent pertussis outbreak, and the new state law requiring the Tdap booster, have awakened a new consciousness in many parents that the task of getting their kids vaccinated does not end at kindergarten. Physicians have an important role in reminding parents of the need for a preteen visit that includes vaccines like that for HPV. Physicians should also be aware that under a new California statute, signed into law by Gov. Jerry Brown last October, they may provide the HPV vaccine to minors without parental consent. In an ideal world, adolescents and parents would both understand the importance of getting the vaccine, but that's not always possible. ◇

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A Political Intrusion into Public Health

Vicki Darrow, MD

Plan B One-Step is a form of emergency contraception commonly referred to as the "morning-after pill." It contains 1.5 mg of a synthetic progesterone to be taken as soon as possible after unprotected sex. It is safe, having virtually no contraindications, and it is effective: when used within three days of exposure to unprotected sex, it will decrease the risk of pregnancy by 89%.[1]

In 2009, the FDA approved Plan B One-Step for sale without a prescription to females 17 and older. Sales to females younger than 17, however, required a prescription. In December 2011, the FDA went one step farther and approved Plan B One-Step for sale without a prescription to females of all ages. But for the first time in history, the Health and Human Services Secretary (Kathleen Sebelius) overruled FDA approval of a drug. As a result, Plan B One-Step for females younger than 17 continues to require a prescription.

In a statement issued after the ruling, FDA Commissioner Dr. Margaret Hamburg wrote that the Center for Drug Evaluation and Research had "determined that the product was safe and effective in adolescent females, that adolescent females understood the product was not for routine use, and that the product would not protect them against sexually transmitted diseases."[2] These findings came from a study by Raymond et al of more than 300 adolescent females 12-17 years old.[3] The study evaluated the participants' understanding that Plan B One-Step was indicated for prevention of pregnancy after unprotected sex; should be taken as soon as possible after sex; does not prevent sexually transmitted diseases or HIV/AIDS; and should not be used in place of regular contraception. Despite these findings, Secretary Sebelius stated that her reason for overruling the FDA decision was because the Raymond study did not include girls who were 11 years old.

Dr. Darrow is a pediatric and adolescent gynecologist at Kaiser Permanente Northern California

In response to Sebelius, Dr. Tina Raine-Bennett of the Women's Health Research Institute at Kaiser Permanente Northern California said, "It is unreasonable and virtually impossible to study the use of emergency contraception in 11-year-olds, because only a small fraction of them will have had sex by that age." Support for Dr. Raine-Bennett's view can be found in a recent *National Vital Statistics Report*, which found that in births to adolescents age 19 and younger, only 1.2% occurred in those less than 15 years old.[4] In studies of teens, only 3% reported having intercourse before age 13, whereas 28% began sexual intercourse between the ages of 15-17, and 60% reported their first intercourse by age 18-19.[5]

In my view, female adolescents of all ages would benefit from easier access to Plan B One-Step, which provides a safe, effective form of emergency contraception. The decision by Secretary Sebelius is an example of the unwanted intrusion of politics into public health. Her decision seems to ignore the evidence-based research and recommendations of numerous scientists, public health agencies (including the CDC and the FDA), and medical associations, such as the American Medical Association, the American Congress of Obstetricians and Gynecologists, the North American Society for Pediatric and Adolescent Gynecology, and the American Academy of Pediatrics.

As a pediatric and adolescent gynecologist for Kaiser Permanente, I work with contraception issues on a daily basis, and I am a strong advocate for programs that increase the availability of emergency contraception for adolescents, such as Kaiser's Adolescent Confidential Services program. When Plan B One-Step is prescribed by a physician for an adolescent within this program, there is no copay or fee. This waiver is especially important because the cost of Plan B One-Step at many pharmacies is around $50, which can deter adolescents from buying it. The program is available 24/7 through the Kaiser call center, which is staffed by nurses and doctors. Many of our pharmacies are also open 24/7, so the adolescent can take the medication as soon as possible after unprotected sex, when it is most effective to prevent pregnancy.

When pediatricians, gynecologists and adolescent medicine specialists at Kaiser meet with an adolescent who is presenting for contraception counseling, they order one or two packs of Plan B One-Step for the adolescent, so that she will have them on hand if she ever has an experience of unprotected sex.

When an adolescent female presents to any lab at Kaiser Permanente for a pregnancy test, she is directed to a counselor with the Teen Pregnancy Prevention program, who then conducts the test. If the test is positive, the adolescent is referred to an ob-gyn. If the test is negative, the counselor advises the adolescent about contraception options, prevention of STDs and the important use of condoms. If the adolescent wants hormonal contraception, the consulting physician orders oral or injectable contraception, along with Plan B One-Step. The adolescent is also counseled on the risks, benefits and side effects of contraception. In addition, the counselor performs risk assessments, conducts a urine gonorrhea and chlamydia test, takes vital signs and schedules follow-up appointments with physicians and/or nurse practitioners.

The Teen Pregnancy Prevention program has significantly decreased the unintended pregnancy rates in adolescents within Kaiser Permanente Northern California. It has also increased contraceptive use in adolescents who are sexually active and has increased the early detection and treatment of chlamydia.

The success of the various Kaiser programs in reducing teen pregnancy rates depends to a large extent on access to Plan B One-Step. Such access is probably even more critical for adolescents who are not covered by Kaiser insurance and may not have the benefit of pregnancy prevention programs.

The decision by Secretary Sebelius to overturn the FDA's evidence-based approval of unrestricted access to Plan B One-Step is an unfortunate precedent. I am hopeful that those of us who advocate for the health and well-being of adolescent women will be able to prevail. Adolescents of all ages deserve access to this important medication, which can prevent an unintended pregnancy that would alter the course of their lives. ◇

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Richard Carmona, MD

Steve Osborn

Dr. Richard Carmona, who served as Surgeon General of the United States from 2002 to 2006, has a longstanding connection to Northern California. After serving as a Special Forces medic during the Vietnam War, he attended medical school at UC San Francisco, where he received the gold-headed cane as the top graduate of 1979. He stayed at UCSF to complete a residency in general and vascular surgery and then became director of Arizona's first regional trauma care system.

During his wide-ranging career, Dr. Carmona has served as professor of surgery and public health at the University of Arizona; as deputy sheriff for Pima County, Arizona; and as vice chairman of Canyon Ranch, a health and wellness company. While he was Surgeon General, he issued a definitive report about the dangers of second-hand smoke.

The following interview with Dr. Carmona was conducted by phone on Jan. 24.

Q: When you were Surgeon General, were there any instances when politicians tried to interfere with your decisions?

A: There were numerous instances over time, and they were actually delineated in congressional testimony in July 2007. Former Surgeon General Koop, former Surgeon General Satcher and myself all went before a congressional committee looking into these issues. All three of us told the same stories about various administrations trying to manipulate, marginalize or forget the scientific truth for political expediency. This has been going on for some time—all Surgeons General have had this problem.

Q: Did you learn how to approach things differently or change the way you presented scientific proposals?

A: You have to stand firm as to what the science is on the issue. As the Surgeon General, your job is to take the best science available and render the scientifically best practice opinion. It is sort of a give and take, and you learn how to stay centered and focused on the best science, and let everybody else do the politics.

For instance, when David Satcher was Surgeon General, he wanted to move the needle exchange program forward, but there was a lot of opposition from the Republican Party based on erroneous information. Yet he knew that needle exchange would reduce disease transmission, HIV, hepatitis, and so on. He stuck to his guns and released his report. It became a very controversial issue politically but not scientifically.

When Everett Koop was Surgeon General in the early 1980s, we were not sure what this disease was that was killing young men with fevers and lymphadenopathy. Scientists found that it was an HIV virus that was ultimately called AIDS, and Koop spoke to the scientists and got the word out to the American public. But when he did that, he was admonished by certain conservative political elements for speaking about these issues in a public forum, about sex and homosexuality and so on. At the time, certain elected officials were telling the public that this was God's way of punishing homosexu-

als. Surgeon General Koop had to stand up and say that's not true. This is an infectious disease that we can prevent.

So you see a theme that goes from Surgeon General to Surgeon General. No matter which side of the aisle you are on, there is an attempt at manipulation. This is why the position of Surgeon General should be independent and should be independently funded. The Surgeon General should be mandated to speak out regularly on the scientific evidence, not the political evidence, on any issue that will affect the health, safety or security of America.

Q: Do you think science should always take precedence, or are there instances when political considerations might be more important than the scientific evidence?

A: I think first and foremost science should always be part of the discussion. I recognize the realities of politics and also that some issues are quite complicated, and that ideology and theology get involved on some of the issues. But science should always be at the table as a guiding factor. The question that needs to be asked all the time is, What is best for the American public?

Science should be a major driving force in how things are done, but there are political realities. How much money is available, and what are the downsides of any policy decision? Could this be positively or negatively disruptive? I don't want to just take science out of context and say ignore all the other things, but it needs to be at the table as a driver for the final decision. You can take these political considerations into account, but always with the thought of what is best for the American citizen, the American public in general.

Q: In a recent instance of politics vs. science, Health and Human Services Secretary Kathleen Sebelius nixed over-the-counter sales of the morning-after pill. Do you think those sales should have been allowed?

A: Let me preface my answer. Not being Surgeon General any more, and not having been involved with her decision, I only know what was in the media and a couple of discussions that I had with friends. Nonetheless, this is an issue I did deal with when I was Surgeon General, when the initial launch of the Plan B morning-after pill was delayed. It was not delayed because of science—it was delayed because of political considerations. It was just an inopportune time, and people didn't want to fight the parties and so on and so forth.

At that time, it was clear to me after talking to the scientists that there was enough science to go ahead and deal with this issue. However, politically everybody wanted to stay away from it because it was such a volatile issue. I think that was a poor decision, especially when we are dealing with unwanted pregnancies and the parties are fighting over pro-choice and pro-life, and here is a scientific method that will decrease the amount of unwanted pregnancies and hence the need for abortion.

In the recent ruling by Secretary Sebelius, she said there wasn't enough science, but clearly the scientists who commented said there was more than enough science. The allegations here show that the system is broken, that we can't make good decisions because we are worried about party political opposition on so many fronts.

Q: In another instance of politics vs. science, President Obama last year rejected a proposed rule from the EPA that would have reduced emissions of smog-causing chemicals. He argued that it would be too costly for industry to implement. What is your view of that decision, recognizing that you are not currently in the administration?

A: Again, I don't have all the facts on that. I have read what was in the media. My concern is that emissions can be harmful, asthma levels go up, we get pulmonary problems and so on, so what can we do to reduce that? If emissions are looked at as a partisan issue and people are fighting over this based on partisan lines, we fail to do what's right for the public.

The fact of the matter is if we find scientific evidence that there are pollutants being created by any industry, it doesn't make a difference what the industry is. The real issue is how do we start to change the way manufacturing is done or emissions are created, and that's going to take a little bit of time. We don't want to be disruptive where we are going to shut businesses down acutely when they are beneficial.

So again, not knowing what the President was faced with when he looked at all sides of this issue, I am giving you a general framework of how I would approach it if I was in a leadership position. I understand that you are telling me these emissions are bad. Where are they coming from? What do we need to do to cut them back? If industry then says okay, we are willing to work with you but it may take a little time because it is going to cost so much and we have to generate revenue, I think those are perfectly legitimate reasons to think about how to implement changes that will benefit the American public.

This is something we are going to be dealing with in perpetuity in any industry because as new science evolves there are better ways to do things that are more efficient, more effective and less toxic. We have to be willing to have those discussions in a nonpartisan way that benefits business but also benefits the American public.

Q: The war on tobacco has been a public health success story, but now we have an enormous obesity epidemic. Do you think that government should wage a similar war on soda pop and other junk foods to try to stem the obesity epidemic?

A: My sense is that government's role should be to raise the level of health literacy to help people make better decisions, and to make sure that the poorest people up to the wealthiest have access to a good, balanced diet of healthy foods that are free of contaminants and organic when possible. I think it is not the right way to go to just admonish somebody for drinking soda pop or going to a fast-food restaurant, because

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where does it stop then? Are we going to have a government agency that is going to decide what is good to eat and what isn't good, and what amounts?

I think the real issue here is to educate the American public and make sure that everyone has access to healthy foods. In doing so, I believe industry will change over time, because if the American public begins to demand healthy choices, industry will move in that direction.

I have a concern about waging a war on anything because where does it stop? Where does that money go that you bring in? We have taxed cigarettes very highly in many states, and one of the challenges with getting states to agree to reduce the amount of tobacco being sold, or in fact ban tobacco, is there is so much revenue being generated now, one that runs public functions and keeps cities moving and pays for public service, that nobody wants to deal with the issue. There really is an incentive not to do away with tobacco because now we have become dependent upon those revenues. So it's not only the intended consequences of what we want to do, we have to look at the unintended consequences, and tobacco is a good example of what's been good and what's been bad.

My sense when I was Surgeon General was always to spend the time and effort with the American public, to raise the level of health literacy, to have them understand that you can find reasonably priced healthy foods in the right amounts, and to stay physically active. For the most part, that will begin to reduce the obesity epidemic without legislating the intent to decrease the obesity epidemic. I think legislation should always be a last resort.

Q: What changes do you think could be made to ensure a better balance between politics and medical science?
A: As I said before, I think the Surgeon General's office should become independent. The Surgeon General should be chosen based on merit from the ranks of the U.S. Public Health Service. They should be career officers and have prerequisite core competency to do the job. Then the nomination should go to the President, and the President should decide just like with the other services.

Just like the President delivers a yearly State of the Union address, I think the Surgeon General should deliver a state of the nation's health, global health, every year. That way it is clear to Congress and the American public what issues our nation is facing. Our elected officials will be more accountable if they are focused on the issues that were presented impartially and nonpartisanly by the Surgeon General.

We also have to do a lot more to make all these discussions transparent to the American public, whether it be tobacco, stem cells, abortion or pollution. The more we can make these discussions transparent and engage the public, the more likely it is that we will make nonpartisan, rational decisions that benefit citizens directly. ◇

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When ED Care is Clearly the Best Option

Jeffrey "Jim" Dietz, MD

In the last issue of *Marin Medicine*, Dr. Dustin Ballard wrote a fascinating article about the "Frequent Fred" phenomenon and discussed how a community might manage patients who overuse emergency departments. But what about the other side of the coin? What are the time-critical situations for which ED care is clearly advantageous?

It goes without saying that a patient suffering cardiac arrest should be brought immediately to an ED, when field resuscitation has been successful or if there is any further chance for resuscitation. It is also obvious that patients with any degree of respiratory distress should access 911 or be immediately referred to the ED. Physicians in the ED have advance airway skills and the equipment needed to stabilize these situations and initiate diagnostic modalities, as well as therapeutic interventions specific to the underlying etiology.

ED intervention is also clearly indicated for some other clinical situations, as detailed below.

STEMI

The standard of care for ST elevation myocardial infarction (STEMI) is emergent direct percutaneous angioplasty, which restores perfusion to injured and threatened myocardium. EDs in Marin County have fortunately had the capability to perform this procedure for the past 20 years. Community education efforts have led to early recognition of STEMI warning symptoms by patients and families. People with diabetes or other neuropathic conditions may present with atypical symptoms, as may a higher percentage of women.

Patients with any suspicion for acute coronary syndrome should have immediate EKGs, which are often performed by paramedics. Should the EKG demonstrate STEMI, the patient should be referred or transported to Kaiser San Rafael or Marin General Hospital, the two STEMI treatment centers in Marin. Furthermore, private physicians or paramedics who detect STEMI should contact the treatment center and whenever possible either fax or otherwise transmit the EKG prior to the patient's arrival. This contact will initiate mobilization of the cath lab team while the patient is en route, reducing time to reperfusion. Times to catheterization in Marin County are excellent—much better than national benchmarks.

Stroke

Just as occlusion of a coronary artery will result in subsequent destruction of cardiac tissue, occlusion of a cerebrovascular artery (stroke) will result in further destruction of brain tissue or failure of less-damaged brain tissue to recover (the "penumbra effect"). Though the indications for stroke intervention are more controversial than for STEMI, early revascularization may result in better outcomes.

The key factor for stroke treatment is time from onset of symptoms, generally defined as when the patient was last seen to be normal. This critical piece of data should be investigated by referring doctors or paramedics who may have access to family members prior to the patient's arrival in the ED. In cases where the patient wakes up with stroke symptoms, the last "normal" time is defined as when they went to sleep. Patients who slept for several hours prior to discovery of stroke symptoms may be excluded from certain time-restricted interventions.

For acute cerebrovascular accidents that meet time and clinical criteria, the primary intervention is intravenous tissue plasminogen activator (tPA). After initial studies of risk and benefit, the use of tPA was recommended for cases where the treatment could be administered within the first three hours after onset of symptoms. Given that tight time frame, many patients were excluded by virtue of time considerations alone. Recently the time window for consideration of intravenous tPA has been extended to 4.5 hours.

Other techniques to restore perfusion (intra-arterial interventions) may be considered even later. The most critical issues are that the patient be identified immediately, CT obtained rapidly, and a determination made expeditiously as to whether the patient meets criteria for either intravenous tPA or other procedures. The public has also been educated about warning signs of

Dr. Dietz chairs the Department of Emergency Medicine at Marin General Hospital.

stroke and the need to seek treatment immediately at one of the three EDs in the county (Kaiser, Marin General, Sutter), each of which is capable of administering IV tPA for stroke.

Other Vascular Emergencies

The admonition that "time is tissue" applies to other organs as well. Patients with the potential for other vascular emergencies should be seen immediately in an ED for evaluation and treatment. Examples include suspected thoracic dissections, abdominal aortic aneurysms, thrombosis of the arterial supply to bowel or extremities, and testicular or ovarian torsion. Local EDs are well prepared to organize the workup and acute interventions for such immediate threats to life and limb.

Trauma

Ten years ago, the County of Marin, with input from local hospitals and the community at large, developed a county trauma system. Marin General was designated as a level III trauma center and is unique among such centers in that it has 24/7 neurosurgical capabilities. Experience has shown repeatedly that victims of major trauma have better outcomes when treated at a trauma center. Paramedics are directed by county EMS policy to take trauma patients who meet established criteria to Marin General. As part of the county plan, Kaiser San Rafael is designated as an EDAT (emergency department approved for trauma) and as such has a greater level of capability than a typical ED.

Sepsis

In recent years, the approach to patients with serious infections has rapidly evolved. Early recognition of patients with the more severe manifestations of systemic infection (severe sepsis and septic shock) benefit from aggressive fluid management, early antibiotics, and other "goal-directed therapy," which may include the use of a central venous catheter-based monitoring. One goal is to provide intensive interventions to patients who are approaching severe sepsis but have not yet fallen off the cliff. The challenge is to identify patients who qualify for such therapy, which is relatively aggressive, as compared with what is usually provided for the typical "flu" patient (and yet may appear quite similar at presentation). ED physicians attempt to make this determination rapidly by assessing vital signs and other clinical findings, along with laboratory and radiologic testing.

Acute Abdomen

The differential diagnosis for acute abdominal pain is extensive. Patients with such pain often require parenteral analgesia plus immediate laboratory and often imaging studies. The results of those studies may lead to emergent or urgent operative intervention. EDs within our hospitals are capable of providing all these services.

Conclusion

In summary, the emergency departments in Marin County will keep taking care of "Frequent Fred" until we find another way to manage his needs. In the meantime, we are well prepared to handle the clinical entities that are truly emergent. ◇

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OBITUARY

Dr. Ted Hiatt, who served as Marin County's public health officer from 1976 to 1992, passed away in January. Born in Canada in 1923, he subsequently moved to the United States and served in the Coast Guard during World War II. After graduating from medical school at the University of Colorado, he started as an on-call physician in Marin County in 1955. He became deputy public health officer in 1971 before assuming the top spot five years later. During his long tenure, he shaped public policy on emergency medical response, AIDS, pediatric health care and many other areas. After retiring, he published "The Power of Kings," a book on political economy.

Retirement Remedies for Physicians

Jonathan Leidy, CFP(R)

The Employee Retirement Income Security Act (ERISA) limits doctors and other individuals who earn more than $115,000 per year from fully contributing to their retirement plans. Indeed, for doctors who earn more than $250,000 per year—the "maximum compensation" as defined by the Internal Revenue Service—the ability to contribute to retirement plans is often capped. No matter what they earn, physicians need creative solutions to ensure that they are aptly prepared for retirement.

ERISA-qualified solutions that have become increasingly popular over the past few years include cross-tested or New Comparability profit-sharing plans, as well as Cash Balance plans. In addition, many physicians are turning to non-ERISA-qualified plans, when additional flexibility is desired.

DB vs. DC

ERISA outlines two basic retirement plan types: defined benefit and defined contribution. Defined benefit (DB) plans are characterized by a known retirement income or "benefit," such as 75% of the average of your last three years' salary. In order to generate the collective retirement income of all the DB participants, an omnibus account is funded each year. The amount of that funding is variable, depending on the current age and earnings of each participant, as well as several assumptions regarding future investment returns and salary growth. If the return in a given year is greater than expected (or salary growth is less), the amount of the following year's contribution decreases; the converse is also true. In that way, DB plans have a known benefit, but an unknown contribution.

The exact opposite is true for defined contribution (DC) plans. With a DC plan, the amount put in each year is known. The funding source is employer contribution (profit sharing), participant contribution (salary deferral), or a combination of both. Permissible amounts are subject to ERISA ratios and caps, but the contribution is a known quantity. What is unknown in a DC plan is the balance of a participant's account at retirement.

Historical abuses at companies like Studebaker and Bethlehem Steel led to a mass migration away from DB plans in favor of DC alternatives. Unfortunately, DC plans have been an abysmal failure from an overall retirement preparedness standpoint, and they have placed significant strain on physicians who are attempting to save for retirement.

So what retirement remedies are available for physicians? The answer depends on several factors, primarily the nature of the doctor's employment. Enter Dr. Freelance and Dr. Salary, both of whom are in their 50s. Dr. Freelance is a self-employed physician who has either created her own practice or has banded together with like-minded physicians to form a group practice. Dr. Salary is an employee who works for a large medical group or hospital foundation.

Dr. Salary's options

For Dr. Salary, the retirement options can be limited. In most cases, he is at the mercy of his employer when it comes to determining which plan types are offered and to whom. Dr. Salary's lack of flexibility, however, can be somewhat counterbalanced by the scale and negotiating power of his employer.

Dr. Salary's employer will most likely provide a 401(k) plan, which allows for tax-deferred savings of up to $17,000 per year, with an additional $5,500 per year in permitted contributions, since Dr. Salary is older than 50. Dr. Salary's employer may also offer to match his salary deferrals up to a certain maximum percentage of compensation contributed, such as 5%. Matching contributions represent "free money" for Dr. Salary, and he should capture them whenever possible.

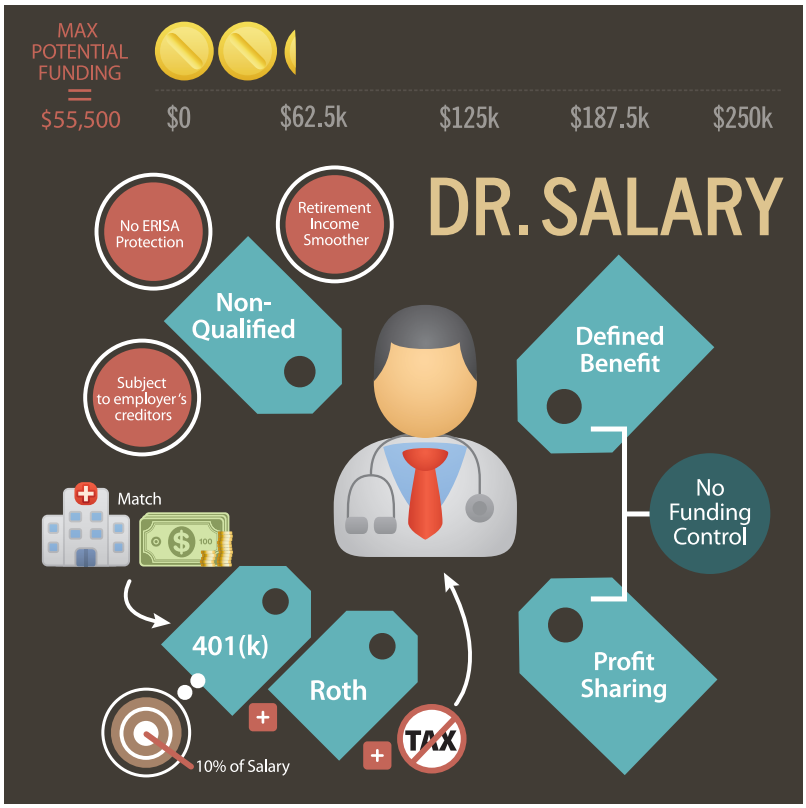
Another option for Dr. Salary, assuming his 401(k) plan permits it, is to make Roth 401(k) contributions. Whereas regular 401(k) contributions are made pre-tax, Roth contributions are made post-tax. At retirement, both the contributions and earnings of a Roth account can be removed tax-free. Given that higher future tax rates

Mr. Leidy is a principal at Portico Wealth Advisors in Larkspur.

seem virtually certain, paying taxes now in exchange for the opportunity to take tax-free retirement distributions likely represents a good trade-off for Dr. Salary, and perhaps makes even greater sense for some of his younger colleagues. And unlike the standard Roth IRA, which has income participation limits, anyone can contribute to a Roth 401(k).

Dr. Salary's retirement plan may also have a profit-sharing feature. Unlike the salary deferral of a 401(k), profit-sharing contributions are made by Dr. Salary's employer. These contributions are usually discretionary, and in combination with his salary deferral, catch-up contribution and match, can total as much as $55,500.

It is also common for large medical employers to provide DB plans for their employees. Although a DB plan represents an excellent opportunity for Dr. Salary to earn a retirement income stream, his participation in the plan is compulsory, with no active decision to save on his part.



Dr. Salary's retirement options.

Lastly, Dr. Salary may be offered non-qualified savings opportunities, including deferred compensation or 457 plans. These are non-ERISA plans and, unlike DB/DC plans, the assets within them are subject to the general claims of his employer's creditors. Deferred compensation plans represent a decent way to smooth income across Dr. Salary's retirement threshold. However, the possibility of his employer defaulting makes them a somewhat risky alternative.

Dr. Freelance's options

For the self-employed Dr. Freelance, the opportunities for retirement savings are more plentiful. She can sponsor most of the plans detailed above, and in doing so, act as both the employer and the employee. This nuance is significant because it affords her the flexibility to control the contribution sources to her account, and thus maintain greater control of her plan's total funding cost.

Beginning again with the standard 401(k) plan, whereas Dr. Salary can maximally defer $17,000 of his earnings this year (plus the additional $5,500 for being over 50), Dr. Freelance can contribute up to $55,500. While Dr. Salary is also entitled to additional contributions from his employer, he is utterly dependent upon his employer to make those contributions, and the combined total can't exceed the $50,000 limit plus the $5,500 catch-up.

For Dr. Freelance, maxing out is easier. When she acts as both employer and employee, her individual 401(k) or Solo(k) allows her to make the maximum contribution of $55,500 with virtually zero compliance headaches. Her Solo(k) also allows her to include her spouse as a plan participant.

When Dr. Freelance takes on additional partners or employees, her retirement situation becomes more complex. ERISA testing rules now come into play that may limit her ability to contribute the maximum amount. The purpose of these rules is to prevent discrimination against rank-and-file employees. As a result, Dr. Freelance and other highly compensated employees (HCEs) who make more than $115,000 per year often cannot even approach the maximum contribution limit.

Dr. Freelance may need to retool her retirement plan to increase her tax-deferral opportunities. One common change she can make is to introduce a Safe Harbor 401(k), which allows employers and employees to make matching contributions to the plan. The match needs to at least equal 4% of salary and be open to all employees. However, the contribution only needs to be made for those employees who actually participate. If Dr. Freelance's staff has a low participation rate, she can max out her own contributions with a relatively reasonable overall funding burden.

Dr. Freelance's other Safe Harbor option is to make a non-elective retirement contribution to all eligible employees at 3% of salary. If most of her staff is inclined to capture the match anyway, the flat 3% is likely the better option. This version of Safe Harbor solves the deferral limitation issue, but the funding cost can be quite high.

New Comparability plans

In addition to the above, Dr. Freelance's retirement options also include New Comparability and Cash Balance plans. New Comparability plans are

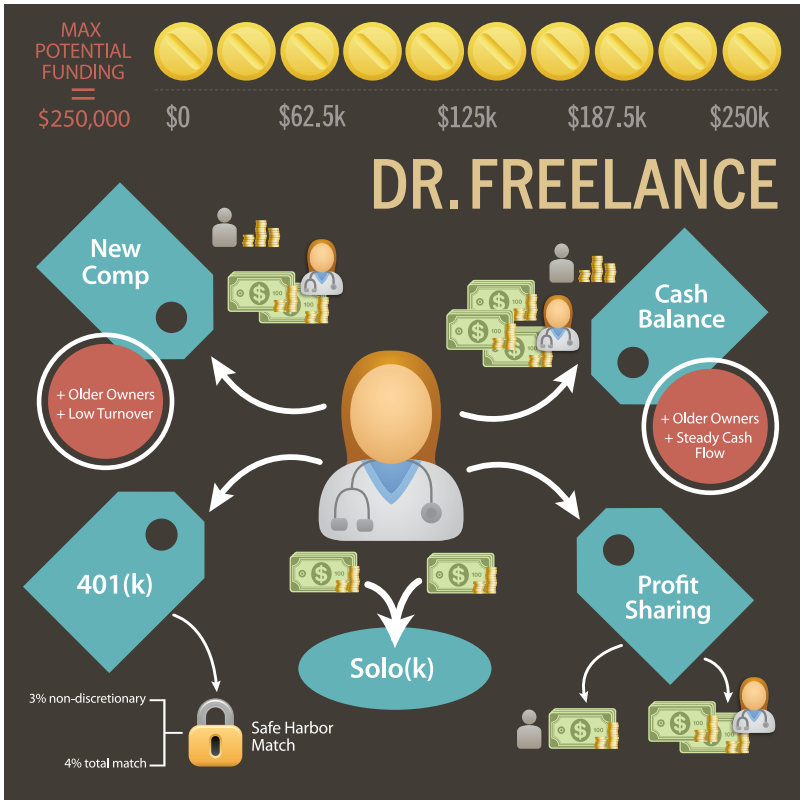
useful when there is a wide spread in age among the individuals in Dr. Freelance's group. Some may be just a couple years away from retirement and have plenty of income to make a retirement plan contribution. Others may be putting their twins through college and have little disposable income. Standard profit sharing requires the same contribution percentage to be applied across all employees. A New Comparability plan, however, allows Dr. Freelance to split her practice into groups, each with its own distinct contribution percentage.

The most basic grouping is owners versus non-owners, whereby the average age of each cohort is compared against the participants in the other group to develop the profit splits. New Comparability plans allow Dr. Freelance and her younger partners to collectively receive a larger portion of the profit-sharing pie, while rank-and-file employees, even older ones, will receive less.

Physician groups often add a third tier to delineate between younger and older owners. This configuration allows for the younger, potentially more cash-strapped docs to take the bulk of their share of profits as current compensation, while Dr. Freelance and her contemporaries can max out their retirement contributions.

It has even become common practice to place each employee in their own distinct group. Doing so allows for maximum flexibility when determining profit-sharing contributions, and prevents Dr. Freelance from having to amend her plan every time an employee leaves.

As with any retirement program, New Comparability plans have their drawbacks. The formulas that govern these plans are intricate and require set-up and maintenance costs. In addition, New Comparability plans are still required to pass all the standard discrimination tests applicable to ERISA plans. Perhaps most important, employee turnover can wreak havoc on plan testing. If Dr. Freelance has a 10-person practice and two of her younger support staff leave, the average age of her rank-and-file group will rise, which will in turn require that a large portion of the profits go to the non-owners.



Dr. Freelance's retirement options.

Cash Balance plans

In all the examples above, one thing remains constant: the maximum that Dr. Freelance can contribute—taking into account the sum of her profit sharing, matching and salary deferrals—is $55,500 per year (the sum of her $50,000 annual limit plus $5,500 per year for being over 50). Is there a plan that allows her to save even more? The answer is yes—a Cash Balance plan.

A Cash Balance plan is actually a hybrid DB/DC plan that uses the same actuarial formulas prevalent in DB plans. Unlike traditional DBs, the target benefit at retirement is not an income stream, but a specific balance. With a Cash Balance plan, Dr. Freelance can target a specific ending value for her retirement account and determine her annual contributions through actuarial calculations that take into account her age and prevailing interest rates.

Cash Balance plans make sense for practices with older doctors and younger staff. Steady cash flows are also critical, because the plans need to be funded for at least three years in order to avoid IRS scrutiny. In addition, the return on the deferred capital from prior years affects the amount of future contributions. Above-average returns in the early years of the plan simply translate into curtailed future contributions. This feature often has doctors (and their retirement plan advisors) making relatively conservative asset allocation decisions within Cash Balance plans.

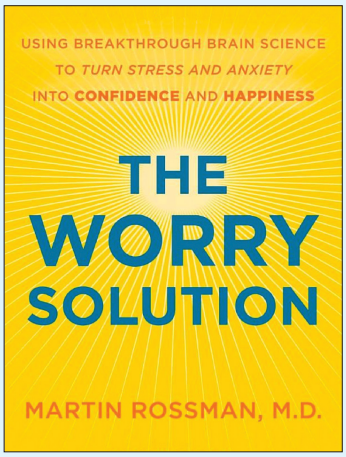
A converse argument can be made if the cash flow of the practice is robust. Early investment success means money is mounting in the tax-deferred Cash Balance plan more quickly. Thus, any surfeit earnings in future years that otherwise would have been required contributions to the Cash Balance plan can simply be treated as standard profit. Conversely, if near-term investment results are poor, more of the practice's future cash flows can be directed toward the Cash Balance plan.

In either case, Dr. Freelance is accepting 100% of the funding risk. To the extent that she is comfortable with her future cash flow projections, she can afford to take more risk for the

CURRENT BOOKS

Harnessing the Power of Worry

Irina deFischer, MD



The Worry Solution: Using Breakthrough Brain Science to Turn Stress and Anxiety into Confidence and Happiness, by Martin Rossman, MD, 256 pages, Crown.

Dr. Martin Rossman, who has practiced mind/body medicine in Greenbrae for many years, is a pioneer in the field of integrative medicine, a clinical instructor at UC San Francisco, and the author of several books. He has taught many physicians and lay people how to use guided imagery for increased personal awareness, self-healing and greater enjoyment of life.

Rossman's newest book, *The Worry Solution,* is based on a series of classes he has taught. In the book, he promises to turn worry upside down and shows how it can be beneficial if handled wisely. His premise is that our instinctive fight-or-flight response to stress, though good for our ancestors in the wild, is ineffectual in dealing with most of the problems we have today.

Bad worry, according to Rossman, leads to suffering and sleepless nights, as well as a host of ailments, both physical and emotional. He maintains that you will be healthier and happier if you learn to modify your response to stress through relaxation; to sort your worries into those you can and can't do anything about; and to tap into your problem-solving inner wisdom using guided imagery and creative visualization.

Rossman also offers a section on "best quality imagery" to strengthen desirable personal qualities. He gives several examples of patients who were helped by these techniques, as well as an overview of current brain research. The book also includes a series of exercises in relaxation and guided imagery, which require the reader to either record the instructions or enlist a helper to read them out loud. There is also an optional CD with Rossman reading the scripts, which I would recommend, as he has a calm and soothing voice.

The Worry Solution is a good introduction to mind-body medicine, a useful tool in the physician's armamentarium. It is written for the lay public, using language that patients can understand. For more details, visit www.worrysolution.com or www.thehealingmind.org. ◇

Dr. deFischer, a family physician and geriatrician at Kaiser Petaluma, chairs the MMS Editorial Board.
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chance to maximize her tax-deferral opportunities.

As with several other retirement options, Cash Balance plans work best in the absence of older, rank-and-file employees. Specifically, the "risk-on" strategy described above can be far less desirable in cases with many such employees, as Dr. Freelance is effectively insuring a greater amount in near-term payouts. That noted, should Dr. Freelance default, her participants' benefits are protected by the Pension Benefit Guaranty Corporation.

Cash Balance plans also need to offer retirees the option of receiving their benefits in the form of a lifetime annuity. This risk, however, can easily be transferred to an insurance company by securing a single-premium, immediate annuity at retirement. Standard DB pension plans can be converted to Cash Balance plans through amendment. The rules specific to conversion are manifold, but the option makes sense for some sponsors.

Summary

Doctors face several challenges when saving for retirement. Although ERISA caps often limit the amount that doctors can defer under standard arrangements, other options exist. Dr. Salary's options relate more to understanding the various plans available to him and maximizing his deferred savings by deftly shifting among them. Capturing all matching contributions and considering the Roth 401(k) option will also be important for him.

For Dr. Freelance, the opportunity set is wider. She can turn to a number of plan design options to help maximize her retirement savings. If her practice has older doctors and younger staff, a Cash Balance plan may make sense. If she has younger doctors in her group, a New Comparability plan may represent a better choice. ◇

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Kentfield Rehabilitation & Specialty Hospital

Simone Adams

Note: *Each issue of* Marin Medicine *includes a self-reported update from one local hospital or clinic, on a rotating basis.*

Illustration of updated patient room at Kentfield Hospital.

Kentfield Rehabilitation & Specialty Hospital is excited to announce that renovation of its physical plant is scheduled to begin this spring. The long-awaited $9 million facelift will encompass the entire hospital and will add both cosmetic improvements and technological advancements.

Kentfield Hospital has been a key component of Marin County's healthcare continuum for nearly four decades. Initially operating as an acute rehab hospital, it transitioned into a specialty hospital for long-term acute care in 1999, focusing on medically complex patients who require extended hospitalization. The hospital's specialty programs include pulmonary disease, complex wound care and neurologic rehabilitation. Several full-time internists work as dedicated hospitalists at the facility, along with specialists in critical care, physiatry, cardiology, infectious disease, plastics, orthopedics and nephrology, to name a few.

According to CEO Ann Gors, the renovation plan has been in the works for the past five years. "The hospital has a proven track record of being financially stable," she said, "so we have reached a point where the investment makes sense." Ever since the hospital was purchased by Vibra Healthcare in 2003, the focus has been on quality outcomes, patient satisfaction and growing core programs as a means to enhance services and improve the hospital's financial position. As Gors explained, the doctors, nurses and ancillary staff have successfully implemented these core values, so they're ready for the next step. She noted, "We are all extremely proud and excited about this project and what it will mean for our patients in the near future."

The cosmetic renovations will include upgrades to all common areas and patient rooms, including new floors, windows, furniture and casework. The design theme will focus on repeating the beautiful colors and landscape of Marin County, as well as the craftsman architectural elements of the building's exterior. Natural textures and tones will be used extensively throughout the updated spaces to add a calm, Zen-like atmosphere and promote a healing environment.

Patient rooms will be enhanced with the addition of ceiling-mounted lift systems to promote safe patient handling. The rooms will be opened up with enlarged windows, built-in casework and updated lighting. The new headwalls will incorporate track systems to better manage and store equipment at the bedside for easy access for patients and medical staff.

Technical advancements planned for the remodel include the addition of a wireless telemetry monitoring system. Chief of Staff Dr. Kip Roebken observed, "This expanded capability will allow our physicians to closely monitor patients newly admitted to the hospital or those patients at highest risk for a

Ms. Adams is communications director for Kentfield Rehabilitation & Specialty Hospital.

change of condition. It will be an excellent tool for enhanced medical monitoring for the complicated patient."

Additionally, the hospital will add a state-of-the-art nurse call system that will integrate with wireless phones to be provisioned to all clinical staff. A middleware technology will forward all alerts, both routine and critical, directly to a handset assigned to staff members. With this new system, the nurse assigned will be able to speak to their patient directly from a handset to a bedside speaker and immediately assess a patient's needs. The system will also relay alarms from critical medical equipment—such as ventilators, IV pumps and oximeters—to the appropriate staff member, creating an enhanced safety net for both patients and medical staff. As Chief Clinical Officer Denise Mace explained, "Kentfield Hospital will be the first specialty hospital in California to implement this new technology; it is a huge step forward in patient satisfaction and safety."

Along with the high-tech enhancements, Kentfield will also be updating its infrastructure. A much-needed bulk oxygen/medical gas delivery system is on this list as well as a new phone system. The hospital will also be rewiring all voice and data cables in preparation for full electronic medical records, as well as capability for future technologies. Some of the space within the present footprint will be reallocated to pharmacy and other critical departments, and the nurse stations will be expanded for a more ergonomic flow. The therapy treatment area will also be expanded with an addition of new kitchen and bath facilities that will help prepare patients for the transition home or the next level of care.

Physiatrist Dr. Deborah Doherty has been medical director of the hospital for the past 25 years and oversees the hospital's Neuro Rehab Program along with internist Dr. Susan Waters. "With this addition," noted Dr. Doherty, "Kentfield Hospital will be specifically designed to meet the rehabilitative needs of catastrophic rehab patients from a physical plant perspective. We have always had the medical expertise, and I am ecstatic that the hospital is investing in the physical environment to best manage my patients."

Renovation will begin in March and is scheduled for completion in the fall of 2013. During the construction period, the hospital will continue to focus on its core values as a means to successfully navigate the transition. Although occupancy will be impacted somewhat during this time, the hospital will continue operations as usual through careful phasing of the construction process. ◇

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The Gift of Poetry

Catharine Clark-Sayles, MD

After high school I stopped writing poetry, feeling that it was not a pastime for a serious scientist. At 40, with the sense that I had lost part of my 20s, I began studying writing with encouragement from writer/gastroenterologist Dr. David Watts and his wife Joan Barranow, a poet who now chairs the English department at Dominican University in San Rafael. I also took a class in poetry at Book Passage in Corte Madera with Margaret Kaufman, who continues as a mentor.

Most summers I try to attend a writing workshop—a sort of summer camp for poets. Since 2003, Dr. Watts has organized a workshop for people writing about health and healing. The workshop began as "Writing the Medical Experience" but has since been renamed "The Healing Art of Writing." It started at Squaw Valley, moved to Sarah Lawrence College, and is now at Dominican University. The next conference will be in June 2011. For doctors, nurses or anyone interested in writing about medicine, the workshop offers a chance to meet with others passionate about writing and to share ideas and inspiration. (For workshop details, visit www.dominican.edu/events/healingart.)

Poetry is a gift, and I am glad to have rediscovered it. I can lose myself for hours while rearranging words into something pleasing. When I think a poem has come together, I experience a lovely euphoria that may fade by the next dawn when revision begins.

I enjoy publication and reading my work in public. Poetry has introduced me to a vibrant community of other writers. I think it has taught me to listen better and made me more sensitive to the unspoken messages from my patients.

I WROTE THE FOLLOWING sonnet at the Sarah Lawrence workshop several years ago, and it was published in the December 2011 issue of *Spillway* magazine. I like using the language and stories of medicine in poetry, and I have a series of poems with glass or window imagery. They may become a manuscript someday.

Pressing to the Glass

In the eternal un-night of the intensive care unit
surrounded by chirps and bleeps and blares of alarm,
sleeping bodies press against the glass of night
uncertain if they are looking in or out, a charm

of figures writ in light on screens overhead.
Nurses in their Saturday scrubs, the chili-pepper print,
talking midnight pot-luck plans, move bed to bed
checking, turning, emptying bags, unconscious of the din

until the ventilators fall into synch: breath in, breath out
and for a space of seconds, no alarms, not one bell
as even the nurses breathe as one, knowing, just about,
of the balance where we all stand, and who may tell,

breath in, breath out, how many million make a life,
as through the window a gibbous moon rides down the night.

THE NEXT POEM came out of an exercise at the Dominican University conference using the form of repeated lines beginning with *if,* followed by lines beginning with *I will not,* followed by lines beginning with *I will.* The poem just seemed to appear with very little revision.

The exercise was presented by John Fox, who regularly teaches seminars in poetic medicine. The poem was published in 2011 in *The Healing Art of Writing,* an anthology from the University of California Press. Although I do not enjoy being called into the ER late at night, there are certain intangible benefits.

Dr. Clark-Sayles is a Greenbrae geriatrician.
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Night Call

If you are in need and it is midnight,
if I leave my bed for the cold darkness,
if I stumble on the step, drive yawning to the ER,
if the light is fluorescent and numbing
and there are cries of despair from the next bed,
I will not resent more than a little
my dream forever gone, not curse you
for the warmth cooling beneath my quilt.
I will not hold you accountable
for the missing hour of sleep.
I will love the crescent moon, the sudden deer
and the hustling skunk on my street as I return.
I will love this midnight world.
I will love my skill.
I will love your need.

Not all my poems are medically themed. My current project is a series of poems with themes from Halloween and old horror movies. I started the series after spending a Halloween evening at a hotel in Seattle where all the wait-staff were dressed as dead celebrities. "Psycho" is a departure in style for me, with short fragmented lines meant to reproduce the "cuts" of that famous shower scene. The poem was published online last October on the website Locuspoint.org.

Psycho

Afterwards, none of us
        showered quite the same.

Black and white film
        chocolate syrup blood;

Janet screamed,
        the water poured,

a shriek of violins.

Two minutes, forty-eight
        seconds, seventy-four cuts

changed what made us
        afraid.

My practice is mostly geriatrics, and dementia is one of the more difficult illnesses I treat. Poetry provides a way to remember and grieve for folks who have become dear over many years. The following poem will be in my new book *Lifeboat*, coming out from Tebot Bach Press this year.

To a Poet Lost to Alzheimer

You also flew on wings you built yourself,
Fragile pinions plumed with verse.
How you stretched to reach the sky!

But I keep imagining the terror as the first feather
Blew away and all around the wax softening with sun.
Did you think then of landing? Did you know already
There was no time and see the glory of a fall
Through closing dark, a comet trail to mark your path?

Icarus was fortunate to drown,
A broken body mourned and put away.
You go on and on, a sad and broken thing,
And you have forgotten that you ever flew.

The poem below will also be in *Lifeboat*. It came out of a momentary encounter with a straggly rose bush while I was waiting for a traffic light to change. I like juxtapositions of unlikely images and contradictions of ideas.

Gift

Someone has shown unreasoned hope
to plant a rose on the median strip;
they've buried prickled sticks then waited
out winter storms and gridlock fumes
for green and petalled shades of pink—

it looks like *Peace*, an editorial choice
for brake squeal, horns and thumping stereo bass.
No one rolls a window down to sniff, but bees
ride down monoxide trails to yellow dust and nectar:
strange vintage laced with a taste of MBTE.

We take what we are given.

Exhaust-soaked air and windshield glare,
a face contorted through the glass:
driver of a silver Jaguar caught,
some urgency delayed by a slow red light.
He mouths a silent curse and pounds his wheel.

I think how like that rose we live: unconscious
of intersections of light and speed;
the acid of what we need; the shine of what is given.

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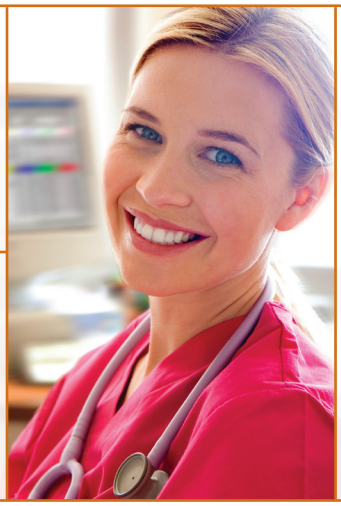

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